		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045740

Facility Name: LaSalle Healthcare Center

Address: 1445 Chartres Street (Number) LaSalle (City) 61301 (Zip Code)

County: LaSalle

Telephone Number: (815) 223-4700 **Fax #** (815) 223-6630

IDPA ID Number: 36-2795206

Date of Initial License for Current Owners: 02/19/1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Chris Henderson **Telephone Number:** (832) 467-6307

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Greg Williams
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,300	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,666	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,966	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	348	145	5,165	5,658	8
9	SNF/PED					9
10	ICF	22,747	5,452	102	28,301	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,095	5,597	5,267	33,959	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.87%

D. How many bed-hold days during this year were paid by Public Aid?
130 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 5,165

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LaSalle Healthcare Center # 0045740 **Report Period Beginning:** 1/01/2004 **Ending:** 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	152,951	10,711	11,940	175,602		175,602		175,602			1
2	Food Purchase		150,158		150,158	(274)	149,884		149,884			2
3	Housekeeping	75,715	13,234	2,321	91,270		91,270		91,270			3
4	Laundry	46,373	9,932	947	57,252		57,252		57,252			4
5	Heat and Other Utilities			80,814	80,814		80,814	166	80,980			5
6	Maintenance	32,234	22,428	7,303	61,965		61,965	91	62,056			6
7	Other (specify):* Waste/Garb-See p3.1			21,140	21,140		21,140		21,140			7
8	**TOTAL General Services**	307,273	206,463	124,465	638,201	(274)	637,927	257	638,184			8
	B. Health Care and Programs											
9	Medical Director			9,619	9,619		9,619		9,619			9
10	Nursing and Medical Records	1,404,365	72,610	28,191	1,505,166		1,505,166	21,458	1,526,624			10
10a	Therapy	183,703	6,443	4,864	195,010		195,010		195,010			10a
11	Activities	62,230	5,732	3,781	71,743	786	72,529		72,529			11
12	Social Services	33,831	59	1,307	35,197		35,197		35,197			12
13	Nurse Aide Training											13
14	Program Transportation			322	322		322	(322)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,684,129	84,844	48,084	1,817,057	786	1,817,843	21,136	1,838,979			16
	C. General Administration											
17	Administrative	80,830			80,830		80,830		80,830			17
18	Directors Fees											18
19	Professional Services			5,792	5,792		5,792		5,792			19
20	Dues, Fees, Subscriptions & Promotions			24,261	24,261		24,261	(8,906)	15,355			20
21	Clerical & General Office Expenses	79,180	12,209	281,024	372,413		372,413	(48,578)	323,835			21
22	Employee Benefits & Payroll Taxes			441,974	441,974	274	442,248	(274)	441,974			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,692	9,692	(1,049)	8,643	10,259	18,902			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			112,880	112,880		112,880	(66,215)	46,665			26
27	Other (specify):*											27
28	**TOTAL General Administration**	160,010	12,209	875,623	1,047,842	(775)	1,047,067	(113,715)	933,352			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,151,412	303,516	1,048,172	3,503,100	(263)	3,502,837	(92,322)	3,410,515			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	12,612
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	8,529
Garbage Service <> Default <> Physical Plant	0
	21,140

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

Facility Name & ID Number LaSalle Healthcare Center # 0037671 **Ending:** 12/31/2004

Meals - adjustment

33,959	Days (Total Patient days)
3	Mult (3 meals a day)
101877	Sub total
186	meals to employess (reported by facility)
102063	Add Sub
150,158	Divide -Pg 3, line 2, column 2
1.47	Cost per day
1.47	Cost per day
186	mult - meal to employees
274	= adjust for pg 2, line 2, column2

Sales Tax - adjustment

150,158	Total Food Cost (page 3,Line 2, col 3)
0.01	Mult
1501.58	Sub total
16.48%	Mult (Pvt pay div by total census)
247	= adjust for nonallowable sale tax for page 5A,
124	= adjust for nonallowable sale tax

Facility Van Expense Reclass - Gas and Repairs

	Total Travel Disallowed	-1048.56	Reclass from line 24
75%	Reclass to Activities	786.42	Reclass to line 11
25%	Reclass to Medically Necessary Trans	262.14	Reclass to line 38
		1048.56	

Facility Name & ID Number LaSalle Healthcare Center #0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			33,521	33,521		33,521	56,859	90,380			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(140)	(140)		(140)		(140)			32
33	Real Estate Taxes			28,452	28,452		28,452	(3,383)	25,069			33
34	Rent-Facility & Grounds			462,377	462,377		462,377	7,258	469,635			34
35	Rent-Equipment & Vehicles			2,554	2,554		2,554	1,379	3,933			35
36	Other (specify):* **Home Office**							11,105	11,105			36
37	**TOTAL Ownership**			526,764	526,764		526,764	73,218	599,982			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					263	263		263			38
39	Ancillary Service Centers		69,182	817	69,999		69,999	27,738	97,737			39
40	Barber and Beauty Shops		120	11,895	12,015		12,015	(12,015)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,450	55,450		55,450		55,450			42
43	Other (specify):* **X-ray/Lab Pg 4.1**			6,357	6,357		6,357		6,357			43
44	**TOTAL Special Cost Centers**		69,302	74,519	143,821	263	144,084	15,723	159,807			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,151,412	372,818	1,649,455	4,173,685		4,173,685	(3,381)	4,170,304			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	0
	-

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	5,931
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	425
	6,357

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(274)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(322)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,500)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,176)	20		28
29	Other-Attach Schedule	(257,960)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (271,232)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	267,851		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 267,851		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,381)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 262	38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 262		47

STATE OF ILLINOIS

LaSalle Healthcare Center

ID# 0045740

Report Period Beginning: 1/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Tax	$ (124)	21	1
2	Small Balance	8	21	2
3	Memorial / Benevolence	(2,189)	21	3
4	Penalities	(4,290)	21	4
5	Donations / Contributions	(100)	21	5
6	Entertainment	(680)	24	6
7	Professional Liability Insurance	(66,215)	26	7
8	Non Allowable Advertising	(8,608)	20	8
9	Adjust Property Tax to Actual	(3,974)	33	9
10	Barber & Beauty	(12,015)	40	10
11	Legal Structure Management	(216,539)	21	11
12	Depreciation Reconciliation	56,859	30	12
13	Misc Receipts	(92)	21	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(257,960)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LaSalle Healthcare Center # 0045740 **Report Period Beginning:** 1/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	166	0	0	0	0	0	0	0	0	0	166	5
6	Maintenance	0	91	0	0	0	0	0	0	0	0	0	91	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	257	0	0	0	0	0	0	0	0	0	257	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	21,458	0	0	0	0	0	0	0	0	0	21,458	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(322)	0	0	0	0	0	0	0	0	0	0	(322)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(322)	21,458	0	0	0	0	0	0	0	0	0	21,136	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,784)	878	0	0	0	0	0	0	0	0	0	(8,906)	20
21	Clerical & General Office Expenses	(234,826)	186,248	0	0	0	0	0	0	0	0	0	(48,578)	21
22	Employee Benefits & Payroll Taxes	(274)	0	0	0	0	0	0	0	0	0	0	(274)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(680)	10,939	0	0	0	0	0	0	0	0	0	10,259	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(66,215)	0	0	0	0	0	0	0	0	0	0	(66,215)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(311,780)	198,065	0	0	0	0	0	0	0	0	0	(113,715)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(312,102)	219,780	0	0	0	0	0	0	0	0	0	(92,322)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LaSalle Healthcare Center # 0045740 **Report Period Beginning:** 1/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	56,859	0	0	0	0	0	0	0	0	0	0	56,859	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(3,974)	591	0	0	0	0	0	0	0	0	0	(3,383)	33
34	Rent-Facility & Grounds	0	7,258	0	0	0	0	0	0	0	0	0	7,258	34
35	Rent-Equipment & Vehicles	0	1,379	0	0	0	0	0	0	0	0	0	1,379	35
36	Other (specify):*	0	11,105	0	0	0	0	0	0	0	0	0	11,105	36
37	**TOTAL Ownership**	52,885	20,333	0	0	0	0	0	0	0	0	0	73,218	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	27,738	0	0	0	0	0	0	0	0	0	27,738	39
40	Barber and Beauty Shops	(12,015)	0	0	0	0	0	0	0	0	0	0	(12,015)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(12,015)	27,738	0	0	0	0	0	0	0	0	0	15,723	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(271,232)	267,851	0	0	0	0	0	0	0	0	0	(3,381)	45

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attachment page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 166	$ 166	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	91	91	2
3	V	39	Professional Services		Mariner Health Care	100.00%	27,738	27,738	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Health Care	100.00%	878	878	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	21,458	21,458	5
6	V	21	Clerical & General Office Exp		Mariner Health Care	100.00%	186,248	186,248	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	10,939	10,939	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%			8
9	V	36	Depreciation		Mariner Health Care	100.00%	11,105	11,105	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	591	591	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	1,379	1,379	11
12	V	34	Leasse Expense		Mariner Health Care	100.00%	7,258	7,258	12
13	V	26	Property Insurance		Mariner Health Care	100.00%			13
14	Total			$			$ 267,851	$ * 267,851	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Related Illinois Nursing Homes as of 12/31/2004

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HealthCare Center	0037689
	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr.Suite 1500
City / State / Zip Code: Alanta, GA 30346
Phone Number: (770) 379-8203
Fax Number: (770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities		1		$ 166	$	1	$ 166	1
2	6	Repair & Maintenance		1		91		1	91	2
3	39	Professional Services		1		27,738		1	27,738	3
4	20	Fees, Subscriptions, Promotions		1		878		1	878	4
5	10	Nursing & Medical Records		1		21,458		1	21,458	5
6	21	Clerical & General Office Exp		1		186,248		1	186,248	6
7	24	Travel & Seminar		1		10,939		1	10,939	7
8	26	Insurance Premium		1		0		1	0	8
9	36	Depreciation		1		11,105		1	11,105	9
10	33	Taxes - Property		1		591		1	591	10
11	35	Rental & Leasing		1		1,379		1	1,379	11
12	34	Leasse Expense		1		7,258		1	7,258	12
13	26	Property Insurance		1				1	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 267,851	$		$ 267,851	25

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number LaSalle Healthcare Center # 0045740 **Report Period Beginning:** 1/01/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 26,982	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 24,478	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,504)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 30,960	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 28,456	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	31,824	8
	2000	24,143	9
	2001	23,548	10
	2002	23,677	11
	2003	24,478	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LaSalle Healthcare Center COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0045740

CONTACT PERSON REGARDING THIS REPORT Chris Henderson

TELEPHONE (832) 467-6307 FAX #: (832) 467-6349

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-09-451-000	PT E 1/2 SE-BEG891.02 NE COR,S4	$ 23,092.50	$ 23,092.50
2.	17-09-449-000	PT SE4-9-33-1 BEG 1291.02' S NE	$ 1,192.84	$ 1,192.84
3.	17-09-450-000	IRREG .19 ACS NE SE	$ 192.60	$ 192.60
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,477.94	$ 24,477.94

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,694 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	See Attached Schedules			1984	24,032	771	20	771		24,032	9
10	See Attached Schedules			1985	50,750	2,537	20	2,537		49,708	10
11	See Attached Schedules			1986	327	16	20	16		307	11
12	See Attached Schedules			1987	5,631	283	20	283		4,885	12
13	See Attached Schedules			1988	4,260	213	20	213		3,485	13
14	See Attached Schedules			1989	8,947	447	20	447		6,878	14
15	See Attached Schedules			1990	19,986	1,000	20	1,000		14,008	15
16	See Attached Schedules			1991	158,584	8,126	20	8,126		107,893	16
17	See Attached Schedules			1992	28,134	1,406	20	1,406		17,795	17
18	See Attached Schedules			1993	95,566	4,778	20	4,778		55,968	18
19	See Attached Schedules			1994	25,902	1,295	20	1,295		13,498	19
20	See Attached Schedules			1992	7,158	359	20	359		5,248	20
21	See Attached Schedules			1993	23,691	1,185	20	1,185		13,276	21
22	See Attached Schedules			1995	14,934	747	20	747		6,262	22
23	See Attached Schedules					8,901		8,901			23
24											24
25	Parking Lot Repairs			1996	2,400	120	20	120		1,008	25
26	Door & Frames			1996	1,679	84	20	84		710	26
27	Therapy Additions			1997	5,709	591	8.5	591		4,237	27
28	Therapy Room			1997	7,232	843	8.5	843		6,039	28
29	A/C repair			1996	1,120	56	20	56		492	29
30	Fire Alarm Systems			1996	14,927	746	20	746		6,269	30
31	Plumbing Repair			1996	772	39	20	39		318	31
32											32
33	Security System			1998	806	40	20	40		258	33
34	Exterior Sign/Flagpole			1998	3,221	268	20	268		1,677	34
35	Water Heater			1998	5,634	232	20	232		1,498	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Allocation -Mariner Post Acute		$	$		$	$	$ 153,388	37
38									38
39	1:90 Gal Water Heater	2000	4,700	470	10	470		2,663	39
40									40
41	7.5 Ton Carrier RoofTop Instl	2001	8,250	825	10	825		3,163	41
42	W/N/C RTU Condenser, Evapcoil	2001	4,842	323	15	323		1,184	42
43									43
44	Rlpc Commerical Water Heater	2002	6,401	640	10	640		1,911	44
45	6-Interior & 1-entrance Door	2002	15,415	771	20	771		1,799	45
46	Rprs Leak under Concrete Floor	2002	1,090	55	20	55		141	46
47	Repl Water Heater	2002	6,850	685	10	685		1,770	47
48									48
49									49
50	Rplc VCT Cove Base	2003	5,000	500	10	500		708	50
51	Rplc Trane Rooftop Unit	2003	4,595	460	10	460		881	51
52	Custom Made Book Cases/Serv Co	2003	6,523	435	15	435		689	52
53	Instl Charge- Nuse call System	2003	4,137	414	10	414		655	53
54	Nurse Call System Equipo	2003	6,407	461	10	461		768	54
55	Rplc VCT- Cove Base -Final Due	2003	5,412	541	10	541		767	55
56									56
57									57
58	AIA Document G702-Roof	2004	44,055	3,671	120	3,671		306	58
59	Roof Instl - App No 2 (Bal Due)	2004	100,283	6,686	120	6,686		557	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 735,362	$ 52,020		$ 52,020	$	$ 517,099	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 342,371	$ 37,872	$ 37,872	$	10	$ 263,779	71
72	Current Year Purchases	11,465	488	488		10	488	72
73	Fully Depreciated Assets	(70,024)						73
74								74
75	TOTALS	$ 283,812	$ 38,360	$ 38,360	$		$ 264,267	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,019,174	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 90,380	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 90,380	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 781,366	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 06/01/1996	$ 772	$ 39	$ 334	86
87	O/H Allocation 12/01/1996	1,531	77	622	87
88	O/H Allocation 08/01/1997	464	23	171	88
89	O/H Allocation 10/01/1997	215	11	80	89
90					90
91	TOTALS	$ 2,982	$ 150	$ 1,207	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nationalwide Health Properties
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1973	101	07/01/89	$ 462,377	10	40	3
4	Additions							4
5								5
6								6
7	TOTAL		101		$ 462,377 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 07/01/1989
    Ending 06/01/2006

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 23,085 Description: See Attachment pg 14.1
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount		Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Matress	12,970.42		03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102	Matress	1,974.88		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	841000000007000				03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	841000000007030	Diswasher	1,190.00		03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeepin	841000000007040	WheelChair Washer	2,145.00		03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050	WheelChair Washer	195.00		03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admi	841000000008000				03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	841000000008100	Copies, Stamp machine Cable	3,466.86		03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plan	841000000008210	Water Softner	1,143.00		03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220				04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100				03/21/03
			23,085.16		Grand Total

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	2445 hrs	$ 52,492		$	$	2,445	$ 52,492	1
2	Licensed Speech and Language Development Therapist	10a-03	594 hrs	23,719				594	23,719	2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	3909 hrs	97,061				3,909	97,061	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-03	# of prescrpts				69,182		69,182	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): HO Profess Svcs						27,738		27,738	13
14	TOTAL			$ 173,272		$	$ 96,920	6,948	$ 270,192	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,150	$	1
2	Cash-Patient Deposits	35,877		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	360,650		3
4	Supply Inventory (priced at)	15,020		4
5	Short-Term Investments			5
6	Prepaid Insurance	260		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 412,957	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	210,412		15
16	Equipment, at Historical Cost	141,523		16
17	Accumulated Depreciation (book methods)	(74,957)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 276,978	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 689,935	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 16,752	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,979		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,882		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,452		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attachment Schd. 17.1	8,823		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 218,888	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attachment Schd. 17.1	(706,934)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (706,934)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (488,046)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,177,981	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 689,935	$	48

***(See instructions.)**

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIIES

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Reconcile with schedule XV, line 9:	0
Difference	0

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	1,138
Misc Dedctns - Employee <> Union Dues <> Default	
Accruals - Insurance <> Accrue HMO Ins <> Default	
Accruals - Insurance <> Self Funded Ins Accr <> Default	
Accruals - Insurance <> Basic Life <> Default	738
Accruals - Insurance <> Lt Dsblty <> Default	242
Accruals - Insurance <> Dental Ins <> Default	-
Accruals - Insurance <> Executive Supp Life <> Default	523
Accruals - Insurance <> Short Term Disability <> Default	-
Accruals - Insurance <> Dependent Life <> Default-Dept	78
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	75
Accruals - Insurance <> NES Insurance <> Default-Dept	-
Accruals - Benefits <> 401k Co Match <> Default	6,030
Total	8,824
Reconcile with schedule XV, line 36:	8,824
Difference	-

OTHER NON-CURRENT ASSETS:	
Excess Reorganized Value <>Excess Reorg Value <> Default	
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	
Total	-
Reconcile with schedule XV, line 23:	0
Difference	-

OTHER NON-CURRENT LIABILITIES::	
Intercompany - Revolver <> Default <> Default	(706,934)
N/P - Mortgage <> Mortgages <> Default	
Total	(706,934)
Reconcile with schedule XV, line 43:	(706,934)
Difference	0

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 998,188	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 998,188	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	179,793	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 179,793	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,177,981	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,391,550	1
2	Discounts and Allowances for all Levels	(2,869,966)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,521,584	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	543,330	6
7	Oxygen	27,091	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 570,421	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,925	13
14	Non-Patient Meals	100	14
15	Telephone, Television and Radio	8,591	15
16	Rental of Facility Space		16
17	Sale of Drugs	133,816	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,376	19
20	Radiology and X-Ray	900	20
21	Other Medical Services	55,673	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 261,381	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Receipts Admin (See Sch pg 19.1)	92	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 92	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,353,478	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	638,201	31
32	Health Care	1,815,057	32
33	General Administration	1,049,842	33
	B. Capital Expense		
34	Ownership	526,764	34
	C. Ancillary Expense		
35	Special Cost Centers	88,371	35
36	Provider Participation Fee	55,450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,173,685	40
41	**Income before Income Taxes (line 30 minus line 40)****	179,793	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 179,793	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SUPPLEMENATAL INCOME SCHEDULE

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending Miscellaneous Receipts<>Default<>Prod<>Vending	0
Miscellaneous Receipts<>Default<>Prod<>Administrative	92

Total	92.00	Difference
Reconcile with schedule XVII, line 28:	92	0

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	-
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-
Miscellaneous Receipts<>Default<>Prod<>Activities	

Total	-	Difference
Reconcile with schedule XVII, line 28a:	0	-

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,189	2,261	$ 66,305	$ 29.33	1
2	Assistant Director of Nursing	432	446	10,253	22.99	2
3	Registered Nurses	14,953	15,446	325,054	21.04	3
4	Licensed Practical Nurses	13,183	13,618	263,397	19.34	4
5	Nurse Aides & Orderlies	68,712	70,978	682,628	9.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,320	4,445	87,884	19.77	7
8	Rehab/Therapy Aides	2,770	2,850	95,819	33.62	8
9	Activity Director	1,932	1,962	23,031	11.74	9
10	Activity Assistants	5,636	5,723	39,199	6.85	10
11	Social Service Workers	3,648	3,697	33,831	9.15	11
12	Dietician					12
13	Food Service Supervisor	2,062	2,098	36,970	17.62	13
14	Head Cook	8,798	8,950	70,117	7.83	14
15	Cook Helpers/Assistants	6,655	6,770	45,863	6.77	15
16	Dishwashers					16
17	Maintenance Workers	2,972	3,003	32,234	10.73	17
18	Housekeepers	11,308	11,581	75,715	6.54	18
19	Laundry	6,353	6,493	46,373	7.14	19
20	Administrator	2,238	2,277	74,876	32.88	20
21	Assistant Administrator					21
22	Other Administrative	1,889	1,922	28,390	14.77	22
23	Office Manager					23
24	Clerical	5,019	5,107	56,744	11.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,170	1,234	10,826	8.77	31
32	Other Health Care(specify)	2,038	2,038	43,902	21.54	32
33	Other(specify) Rounding			1		33
34	TOTAL (lines 1 - 33)	168,277	172,899	$ 2,149,412 *	$ 12.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	210	$ 8,616	1-3	35
36	Medical Director	84	9,450	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	410	21,458	10-3	38
39	Pharmacist Consultant	77	3,320	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	2,058	11-3	44
45	Social Service Consultant	19	1,037	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	837	$ 45,939		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathleen Dilbeck	Administrator	100	$ 80,830
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,830

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Exhibit 1	See Attached Exhibit 1	$ 5,792
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 5,792

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,352
Unemployment Compensation Insurance	52,574
FICA Taxes	157,427
Employee Health Insurance	114,300
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension / Retirement	5,950
Insurance Life	2,903
Other Benefits	8,468
Home Office Allocation	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 441,974

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,911
Health Care Worker Background Check	
(Indicate # of checks performed)	1,402
Other License Fees	2,515
Dues	5,649
Home Office Allocation	878
Total Advertising	9,785
Less: Public Relations Expense	( )
Non-allowable advertising	(8,609)
Yellow page advertising	(1,176)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,355

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 407
In-State Travel	6,576
Home Office Allocation	10,939
Seminar Expense	1,660
Entertainment Expense	(680)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,902

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LaSalle Healthcare Center # 0045740 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LaSalle Healthcare Center # 0045740 **Report Period Beginning:** 1/01/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois HealthCare Association - $4,851**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,049** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,450**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **274** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **274**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.